

ST. BARTHOLOMEW'S HOSPITAL JOURNAL



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Calendar

DECEMBER

- Thurs. 8—Squash v. Jeu de Paume (H)
6-30 p.m.
- Sat. 10—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballentine
R.U.F.C. v. Rugby (H)
- Tues. 13—Squash—Cumberland Cup
- Wed. 14—A.F.C. v. U.C.H.
- Thurs. 15—Squash v. Aspro (A) 6-30 p.m.
- Sat. 17—On duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton Hewer
R.U.F.C. v. K.C.S. Old Boys (H)
A.F.C. v. King George's House
Y.M.C.A. (H)
- Sat. 24—On duty: Medical and Surgical
Units
Mr. George Ellis
- Sun. 25—Christmas Day
- Mon. 26—Ward Shows
- Tues. 27—Ward Shows
- Wed. 28—Pot Pourri
- Thurs. 29—Pot Pourri
- Fri. 30—Pot Pourri and Party
- Sat. 31—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
R.U.F.C. v. Old Rutlishians

Editorial

THERE have been several inconclusive discussions about the structure of pre-registration appointments. The suggestion of having an extra pre-registration year was, for example, discussed in 1959 by the B.M.S.A. For those who favour the idea, the course seems clear. Knowledge has increased and experience must go hand in hand. The obvious solution lies in further training. And nobody is able to deny the advantages of progressing to obstetrics and paediatrics after medical and surgical jobs. A clever M.P. might also be quick to realise how some of the problems of staffing hospitals at a junior level could be overcome in this way.

On the other hand is the student who is forced to proceed through a long and, in so many ways, outdated medical training. At the end of this time he emerges from his final examinations with registration only a year away. When registered some will choose to do a further house appointment, some may decide to spend a year as a trainee in a general practice.

If there is to be a change, two important things must be remembered. The first is that if the time before registration is to be lengthened, there must be an honest effort to shorten and change the course before the final examinations. The second point of importance is that any deliberations about the changes must be conducted openly with

full representation from hospital staff and Ministry Officials.

It would be very unfortunate for any government to link a change in the structure of house appointments with, for example, an increase in salary. The connection would appear almost intentional instead of a coincidence resulting from an honest wish to increase salaries, an appreciation of a need for further experience and a problem of staffing hospitals.

However, it has been reported that the Government have plans to increase the pre-registration period from one to two years, at the same time increasing the salary to £820. On October 28th, the *Evening Standard* described the Government's behaviour on the matter as "furtive." On the same day there was an official denial from both the Ministry of Health and the General Medical Council. It is very reassuring to think that all these rumours have been officially denied. But until the matter is settled there will be some who are suspicious of what might follow the rise in salary.

Quidquid id est, timeo Danaos et dona ferentis.

Fifty Years Ago

A Case of Loss of Memory.

The following case may be of interest to readers of the *Journal*.

While on duty as house-physician in the surgery in 19—, a patient was brought in at 5-30 p.m. complaining that she had completely lost her memory. The patient was obviously an educated girl, about twenty-three years of age. The patient, who spoke with a slight American accent, stated that about midday she found herself in Lincoln's Inn Fields without the slightest idea who she was; she looked in her pockets and found her name on her handkerchief, and a small piece of paper with a number written on it, together with the names of several towns in England, and on the opposite side the surname of a person, B——.

Being rather busy I asked the patient to sit down for half-an-hour. At the end of this time the patient was getting very anxious but was not at all desirous for me to communicate with the police. This made one think that the case was possibly not genuine.

The patient was then left for two hours, and at the end of this time she could remem-

ber that she had had an operation on her knee by a surgeon in Harley Street, and that she had been to America.

I rang up the surgeon on the telephone and he remembered the case perfectly, and was able to say to whom the name B—— on the paper referred.

Thinking by this time that the case must be genuine I decided to try a method that had been successful in somewhat similar cases before. The method, shortly, is this—first to get the patient to think of some piece of furniture in a room in which she has slept. In this case I suggested the wardrobe. Having got this point in memory, the next thing to do is to make up a probable story of what the patient did. The patient is then often able to contradict it and say what did happen. In this way it is possible to advance from one point to another. In this particular case my object was to try and make the patient's memory travel from the room in which she slept to the dining-room and then out into the street, and then to remember the number on the door as she left the house, but in this I was unsuccessful; she could only remember the colour of the door. I will not put in all the stages which eventually led to the complete recovery of her memory, but will quote one of the "probable stories." The patient's memory had got so far as to remember that she was at one time in Birmingham.

So I said, "Then you came by train to Paddington?" She replied, "No, I came to Euston." "You then took a cab and paid him?" "No, I took a taxi, the fare was 4s. 6d." "You then told him to drive to —?" "But here the memory was blank: The patient remembered passing a big hospital supported by voluntary contributions, after passing "Jay's" in a park. This was obviously St. George's.

In this way it took two and a half hour's solid conversation of the above description to get the patient's memory back to the address she was staying at, and the name of her relations who owned the house.

Most people who read the above case will possibly be inclined to think that it was not genuine. I can only say that all the nurses and people who saw the case believed it genuine; and in my mind there is not a shadow of doubt, as I have seen the patient once or twice since, and am indebted to her for permission to publish the case.

News in Brief

SIR JAMES PATERSON ROSS gave his last lecture, as a member of the staff, at Charterhouse. Although it was primarily intended for the new pre-clinical entry, the hall was packed with all members of the hospital.

SIR GEOFFREY KEYNES, at the first British Congress on the History of Medicine and Pharmacy, was awarded an Honorary Fellowship.

SIR GEORGE AYLWYN has retired from the presidency of the Medical College. Our next issue will have a report on the ceremony in which Sir George was installed as an Honorary Perpetual Student of the Hospital in appreciation for all his work.

MR. M. W. PERRIN of the Wellcome Foundation is the newly elected President of the College.

MR. H. B. STALLARD has been elected an Hunterian Professor of the Royal College of Surgeons, 1960-61.

THE NEW PATHOLOGY Lecture Hall and Class Room are nearly completed. A short trial of the seats has shown that they are very much more comfortable than the new seats in the Clinical Lecture Theatre!

A NEW DINING ROOM for the House was opened on November 14th. It is situated in the basement of the hospital between the medical and surgical wings.

TWO COPIES of a new manual for official visitors to hospitals are being sent to every Hospital Management Committee in the United Kingdom. Committee members are advised that their own powers of observation may often be a surer guide than answers to questions. Later there is a note of caution, "It is inadvisable that matters of policy should be discussed, or promises made to members of the staff, while going around the hospital."

Students' Union

Finance was the main subject of discussion at the Council meeting held on September 14th. The president, Mr. A. H. Hunt, took the chair. Following discussion on a Financial Committee recommendation, the Council decided that future club tours would be financed from a separate tour fund. This fund would be distributed amongst the clubs on a man-per-day basis, allowing for a reasonable number of players and reserves. To avoid interference with tours previously arranged it was decided that of the £189 available this year the Rugby Club should receive £100. The remainder, plus £50 from either the 1959-60 budget surplus or from the contingencies fund, would be allocated to the other clubs for tours on the man-per-day basis.

A copy of Standing Orders on Procedure at Meetings of St. Bartholomew's Hospital Students' Union was considered and approved by the Council.

As there was a strong desire within the student body to mark the retirement of Professor Sir James Paterson Ross and to show their appreciation to him, the Council decided to organise a presentation to which all students were invited to subscribe.

Mr. Hood reported that dances for the remainder of this year had been allocated as follows:

- October: Boat Club.
- November: Soccer Club.
- December: Rugby Club (Ball).

This was at the rate of one dance per calendar month which was in accordance with the last instructions received from the Warden of College Hall.

Rifle Club: (a) Honours Colours were awarded to two members of the Club; Miss A. M. Holloway and Mr. A. M. Ward.

(b) Mr. Ward pointed out that since the Club had been unable to use the miniature range at the Hospital, the G.P.O. had kindly offered the use of their range every Wednesday afternoon. Any student wishing to avail himself of such facilities should apply to the Rifle Club for the necessary permit.

Mr. Hunt also presided at a Meeting of the Students' Union Council held on Wednesday, October 12th in the Recreation Room at Charterhouse Square.

Mr. Hood reported that he had obtained a William IV sugar basin (1834) for the presentation to Professor Sir James Paterson Ross on the occasion of his retirement.

Mr. Howes explained that the Medical College had decided to institute parking rules at Charterhouse Square. This was necessitated by the building development due to start this term on the present car park. Students had been granted the use of the car park behind College Hall. Short term parking of up to two hours would be allowed throughout the day in certain areas of the square. The Council decided that the car park allotted to students should be reserved for residents but hoped that future development plans would include facilities for student parking.

Mr. Hood reported that Mr. Ellis, the Warden of the College, had decided that one dance per month would be allowed for the time being and in due course the position would be reviewed. The Sub-Committee on Dances set up in June was thus disbanded.

The Council agreed to send three student representatives to the forthcoming Annual General Meeting of the B.M.S.A. to be held at Whitley Bay on November 11th, 12th and 13th. A grant was allocated to these representatives, who would be empowered to speak on behalf of all Bart's students.

Mr. Thomas informed the Council that stricter fire and seating arrangements would have to be enforced at the next Pot Pourri to be held on December 28th, 29th and 30th, at the Cripplegate Theatre. All scenery had to be fire-proofed and no standing would be allowed in the balcony. Regarding Ward Shows Mr. Thomas stated that they would not be held on Christmas Day this year, it being a Sunday.

Abernethian Society

On October 13th, the Society was addressed by Lord Cohen of Birkenhead. He took as his subject, "Straight Thinking in Medicine." He commenced by stressing that to apply logic to medicine, it was necessary to start with facts and that these should be clearly distinguished from opinions. He also compared the physical examination of the patient with a painting which could be excellent but there could still be various interpretations of what was seen unless the previous events were known. Lord Cohen then went on to describe and illustrate eight of the possible errors of logic that were frequently per-

petrated once the facts and the history were known. One of the first errors was generalisation from inadequate data. This was at times inevitable in medicine and such aphorisms as "commonest things are commonest" had their value, though the concept of all symptoms being covered by one diagnosis was erroneous. In fact, more than one diagnosis was possible providing that there was not an unnecessary elaboration of diagnosis.

Premature extrapolation from inadequate data was a common fault as was also the "*post hoc ergo propter hoc*" type of fallacy. It was often observed that a patient improved after treatment though his rate of recovery without treatment might have been as rapid. Argument by false analogy and complete faith in authoritative statements also led to error. When Vesalius examined the intraventricular septum, he found no channels as required by the Galenic theory, but was satisfied by the comment that "We are driven to wonder at the handiwork of the Almighty that blood can sweat from the left to the right side of the heart without there being visible pores." He thought that in modern times, no work could be done without accepting authoritative statements but if these clashed with observation they should be challenged. Allied to this was the "*argumentum ad hominem*" and finally the fallacy of figures which had been aptly exposed by Schiller who had said that "Nothing has a greater effect on the human mind than nonsense supported by technicalities." Lord Cohen concluded by wishing success to the freshmen present at the meeting and an entertaining vote of thanks was proposed by Dr. Cullinan. The meeting was held in the Great Hall which was warmed by enormous fires in the grates and provided a delightful setting for the occasion.

January—December, 1960

President: Miss J. E. Angell James

Secretary: Dr. J. C. Crawhall

Treasurer: P. J. Watkins

Committee: H. White, R. J. Wilson, T. Hudson

Charterhouse Representative: M. Lipsedge

Presidents of the Abernethian Society have been made Honorary Life Members of the Students Clinical Society, University College Hospital, Ibadan, Nigeria.

XIV Decennial Club

The fifth Annual Meeting is to be held this year in the White Hart on Saturday, December 10th from 6-30 p.m. to 11-30 p.m.

There will be a running buffet and drinks available at bar prices. Subscription for those attending is 10s.

All those who entered the Medical College either in Charterhouse or the Hospital direct between 1945 and 1955 and who are now qualified are eligible as members.

The Hon. Secretaries would be grateful to receive notification of any changes of address.

Medical Staff

SURGICAL PROFESSORIAL UNIT.—Director: Professor G. W. Taylor, October 1st, (succeeds Professor Sir James Paterson Ross).

MR. TUCKWELL'S FIRM (from October 1st).—Registrar (Chief Assistant): Mr. Harvey Ross, October 1st (succeeds R. V. Fiddian).

DEPT. OF PSYCHOLOGICAL MEDICINE.—Consultant: Dr. C. M. B. Pare, September 19th.

EYE DEPARTMENT.—Registrar, part-time: Mr. J. E. Cairns, October 1st (succeeds M. S. Wilson).

NEUROLOGY DEPARTMENT.—Senior Registrar (Chief Assistant): Dr. F. Lees, October 1st (succeeds K. W. G. Heathfield).

E.N.T. DEPARTMENT.—G.P. Assistant: Dr. A. Ross, October 1st (succeeds S. Shere).

DEPARTMENT OF DIAGNOSTIC RADIOLOGY.—Registrar: Dr. P. McDonald, October 1st.

MR. NAUNTON MORGAN'S FIRM.—Senior Registrar (Chief Assistant): Mr. J. D. Griffiths, October 1st (succeeds W. M. Keynes). Junior Registrar: Mr. P. J. G. Smart, November 1st.

MR. HUNT'S FIRM.—Senior Registrar (Chief Assistant): Mr. T. Early, September 5th (in place of Mr. Knipe who is in America for one year).

DR. CULLINAN'S FIRM.—Junior Registrar: Mr. J. T. Silverstone, October 1st.

MEDICAL UNIT.—Junior Registrar: Mr. B. P. Harrold, September 1st.

DR. BODLEY SCOTT'S FIRM.—Junior Registrar: Mr. J. S. Malpas, November 1st.

DR. HAYWARD'S FIRM.—Junior Registrar: Mr. T. W. Gibson, November 1st.

Engagements

BONN—GOULD.—The engagement is announced between John Anthony Bonn and Audrey Ann Gould.

SIMS—HARTLEY.—The engagement is announced between Dr. Robin Owen Stroud Sims and Dr. Jennifer Ann Hartley.

STANTON-ELLIS—FOALE.—The engagement is announced between Dr. David Michael Stanton-Ellis and Glenda Elizabeth Foale.

STEPHENSON—GARNHAM.—The engagement is announced between Dr. Charles Graham Stephenson and Carolyn Ismea Garnham.

VISICK—PATTINSON.—The engagement is announced between James Hedley Visick and Angela Kaye Pattinson.

WHITE—WRIGHT.—The engagement is announced between Dr. Roger G. White and Susie Wright.

WINCE—MORRIS.—The engagement is announced between Dr. Walter Hugh Dowling Wince and Muriel Beatrice Morris.

Births

BLOMFIELD.—On September 15th, to Joan, wife of Dr. Douglas Miles Blomfield, a son.

BROOKS.—On September 29th, to Mary and Dr. W. V. Brooks, a son (Clive William), brother to Robert and Mary Anne.

CAIRNS.—On October 1st, to Mary and Dr. John David Cairns, in Toronto, a daughter (Patricia Davidson).

ELLIOTT.—On September 29th, to June Margaret, wife of Dr. David Hallen Elliott, a daughter (Joanna Ruth).

FARROW.—On September 9th, to Ann and Lewis Farrow, a daughter (Katherine Louise).

HAIGH.—On October 5th, to Sanda and Dr. Adrian Haigh, a daughter (Sarah), sister for Joanna, Amanda and Andrew.

JONES.—On September 22nd, to June and Dr. John M. Jones, a son, a brother for Richard.

OGDEN.—On September 15th, to Barbara and Dr. William S. Ogden, a son (Christopher William), brother for Susan.

TUCKWELL.—On September 29th, to Sally and Barry Tuckwell, a son.

Deaths

BEIT.—On September 13th, Francis Victor Owen Beit, Lt. Col., I.M.S. (Rtd.), aged 86. Qualified 1897.

COATES.—On October 8th, Miriam Darcus Coates, formerly Ward Sister of St. Bartholomew's Hospital.

EVANS.—On October 4th, Dr. William Burnett Evans, aged 53. Qualified 1932.

PINKERTON.—On October 9th, suddenly at sea returning from New Zealand, Major John McLean Pinkerton, M.C., F.R.C.S., Qualified 1914.

TATE.—On October 5th, Dr. James Tate. Qualified 1914.

TERRY.—On October 3rd, at Evanstown, Illinois, Dr. Richard Barratt Terry. Qualified 1946.

WALMSLEY.—On September 12th, Dr. Nicholas Walmisley, in his 91st year. Qualified 1900.

Examination Results

UNIVERSITY OF LONDON SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES

June, 1960

Pass:

Brown, M. E. A.
Campbell-Smith, S.
Crawley, P.S.
Goodall, D.
Hamilton, G. R. S. A.
Hardy, F. J. R.
Jones, D. V.

The Early Life of Sir Thomas Dunhill

Note : This account of Sir Thomas Dunhill's early life was sent in response to a request for some account of him when I was preparing the Dunhill Memorial Lecture for the Fourth International Goitre Conference in London, July 1960. It was written by Dunhill's cousin, Miss Jean Peel, of Inverleigh, Victoria, Australia, with the help of his

youngest uncle, Mr. Charles Herbert Peel, now aged 88. I was able to use only a part of the account in my lecture, and Miss Peel has kindly agreed to its being printed in full in the St. Bartholomew's Hospital Journal.

Geoffrey Keynes

IN the year 1852 George Peel brought his bride—both of Grantham, England, out to Australia. After sailing for 13 weeks they landed at Point Henry, near Geelong, having £1 which had been slipped into the bride's hand on leaving, and his kit of tools. Sickness had prevented them from coming a year earlier, George Peel had contracted typhoid fever and had used up all his savings, but the shipping agents said they would take them when they were better, as they had paid their passage. They had to pay 6s. for a barrel of water as soon as they landed. George Peel was a stone mason and immediately obtained work in Geelong.

After two or three years he moved to Inverleigh, 20 miles west, camping on the bank of the Barwon River. He soon obtained land near the Leigh and Barwon Rivers and there built a home, which is still the home of Charles Herbert, the youngest of their family. It was in September 24th, 1856, that Mary Elizabeth was born, and a new room was added to their home.

At the age of 19 years, Mary married John Webster Dunhill, who had come from Yorkshire, and was an overseer on a Cattle Station at Tragowel near Kerang in northern Victoria. It was summer time, during a heat wave a year later, with the temperature at 110 degrees in the shade, and without medical aid, on December 3rd, 1876, that their first boy Thomas Peel Dunhill was born.

The nearest railway was 80 miles away and from there everything had to be brought by waggon. A number of Aboriginal Tribes still lived in those northern areas.

When Tom was a little more than a year and 4 months old and before his brother was born, his father contracted typhoid fever, again there was no Doctor to consult and after a brief illness, he died at the age of 26 years. Mrs. Dunhill returned to her mother and father at Inverleigh, and there at Tower Hill, John Webster was born. After a year or two her father built her a home in close proximity to the old home.

When Tom and John were old enough they went to school at the Inverleigh State School. His mother's youngest brother, Charles Herbert, who is the only surviving member of their family, and who was just 5 years older than Tom, took young Tom on his first day to school, and the master asked him his name and he said, "Thomas Peel Dunhill Esquire", and the master asked if he had any spurs?

The two boys were great mates with their uncles Will, Fred and Bert, and did most things healthy country boys do.

It was a good mile to walk to school and for their lunch they had a solid, but wholesome, home-made yeast bun. On his last visit to "Tower Hill", he still had vivid memories of being taken to school, walking past Mrs. Close's house, through the quarry, over the Leigh River bridge and could name the people who then lived in homes they passed. He also remembered a very big flood when Will had to carry the fowls up from the stockyard holding them in his hands high above the water.

When Tom was 12 years old his mother married again, to William Laury, a mine manager of Daylesford. Gold mining was in full swing by then. The boys continued their education at Daylesford Grammar School. "Paradise Lost" was a prize presented to Tom in 1890.

Tom wanted to become a chemist, so he became an apprentice to a chemist at Daylesford, as well as winning scholarships which enabled him to attend the Ballarat School of Mines for lectures.

When reminiscing in a letter of November 28th, 1956, he wrote, "when I was doing my course as a chemist, I used to catch a train from Daylesford to Ballarat after a day's work, to attend my lectures, get up at 2.30 a.m. next morning, walk two miles to Ballarat station to catch the train at 3.30 a.m. Spend three hours in the train, reach Daylesford at 6.30—still almost an hour before daylight in the winter and be ready to open the chemist's shop at 8 o'clock. In my first year at the University John and I used to get lunch in Melbourne for sixpence each, and by buying a dozen tickets at a time, we got it for fivepence halfpenny. One of my happiest memories is the drives with you (Bert) when you were delivering bread around Shelford and Dorog (neighbouring townships) and you would give me a tart made of that crisp pastry. I can remember

the songs you used to sing—I could even now, sing them back to you, but strangely I have no musical voice and cannot sing a note.

"I suppose some people would say that I was ambitious, I was not, and never consciously had a scrap of ambition, something just pushed me on. I have never asked for anything that I have got, never applied for any position. They just came. I was staying with Edith in Carlisle, 250 miles away, when I saw in the "London Times" that I had been appointed Surgeon to the Royal Household. I was in France when I received a cable from Lord Dawson asking me if I would accept promotion as surgeon to King George V, and years later, I was in Norway when I received a cable asking if I would accept the position of Sergeant Surgeon to George VI. That is just how it all happened, my pen just ran away with me."

While at Daylesford he and John built a canvas canoe and tried it out on the lake there. The skeleton or ribs of that canoe are still in the roof of our barn at "Tower Hill", and one of his cousin's sons last year used it as a pattern to build his canoe.

Canoeing and fishing were his favourite hobbies. Many holidays were spent at "Tower Hill", and each summer the "Peel" family would rent a house at Lorne for a month, and often during that time Mr. and Mrs. Laury, Tom and John would join the parties and go too. Once when they were walking around the rocks Tom happened to drop his pocket knife down a big crevasse in the rocks and when the waves receded he made an attempt to retrieve it. After several unsuccessful attempts he said, "I am going to get that knife next time. You (Bert) hold on to my legs and keep me down," but he never found his knife. He and the party enjoyed many days fishing and he wrote in 1957, when recalling those days at home, "I can smell the frying "Mullet" and occasionally "Sweep" as well as if it had been yesterday".

He loved the deep firm gullies and beautiful pink heath and asked "were there still black cockatoos in the clumps of gum trees near the beach? and I remember the day when Fred, John and I were all swept off the rocky end of the ledge into the bay beyond. I know from that experience and others when canoeing down the Snowy river, that drowning is not painful".

As soon as he qualified as a chemist, he opened a pharmacy shop at Rochester, a remote up country town in the North of Victoria.

It was while there, that he got the urge to take up medicine, and as soon as he had sufficient money he went to "Ormond College", Melbourne University, as a medical student. He was very successful in his studies, winning many scholarships, and taking first class honours in many exams.

It was while he was at "Ormond" that he became ambitious to help people suffering from goitre.

An Inverleigh lady, a Mrs. Alderson, was a goitre sufferer and under Tom's instruction she kept goats, which he used to experiment on.

Later on she let him operate on her. This was his first goitre operation, which proved successful as Mrs. Alderson lived to be 89 years of age.

His brother John became a dentist, and then he too studied Medicine, but at "Queen's College". During their University days he and John with different parties undertook several hazardous trips down the Snowy River. We have a photo taken on top of Mt. Thoscinsko in 1901, and several of Colonel Bridges, Professor Parnell, and Mr. Cornwall (registrar of the University) and Tom in 1904. The first time they bought two folding Canadian canoes for easy transport, these had a watertight compartment where they kept their food, etc.

They went to Dalgety in New South Wales, where on two horses they transported

the canoes to the Snowy River, "across the open end of the big horseshoe curve which the Snowy takes below Dalgety, we launched and started from there, before the river enters the gorges through the Snowy ranges. It drops continuously from its rise above Jindabyne to the neighbourhood of Buchan". "Three of us on a long rope frequently used to get the bow of the canoe at the right angle to make it possible to enter the rapids". (The above is a description taken from the back of some of the photos taken on those trips.) Another shows "how rocks submerged and half submerged create a difficult problem and the swiftness with which the steersman has to react to prevent capsize and perhaps wrecking the canoe", yet another shows their tent, "the one and only night they put it up, showing Cornwall, Dunhill, Parnell and Bridges taking the photo".

The Snowy was a wild treacherous swift-flowing river with many hazardous rapids to negotiate and many times they were thrown out and their canoes wrecked, but they patched them up and off again to explore more river. Arriving at Buchan, the first man they met was an old school mate from Inverleigh. They did not know each other at first, but after talking for awhile they recognised each other. Dan Neve (for that was his name) said he had an appendicitis, and Tom said he was a qualified doctor, so later on in Melbourne he performed the operation.

Tom was one of the top eight to qualify for a doctor in 1903 and this enabled him to practice at the Melbourne Hospital. He took his M.D. in 1906.

Belly Laugh

by R. N. W. Price

The air was electric, the atmosphere tense;
The patients were gripped by an air of suspense;
Nobody uttered or dared make a sound,
For the Chief was beginning his surgical round.

He stood in thought at the head of the ward,
His students behind him, all seemingly bored—
Who was he going to teach on today,
And whose naked torso was up for display ?

The houseman suggested in reverent awe
His humble opinion that bed number four
Was probably quite the best case one could find,
And a good exercise for the medical mind.

The Chief, in agreement, just nodded his head,
And straightway approached the aforementioned bed
Whilst the dresser concerned, quietly cursing his luck,
Slowly emerged with his notes from the rack.

The patients relaxed once again, save this man,
Who nervously peeled back his sheets and began
To expose for the students his pendulous girth,
Which, rightly or wrongly, caused no end of mirth.

For there stamped in letters an inch or two high
Was written a warning for all to espy;
And the words on his abdomen set for display ? . . .
NOT TO BE OPENED BEFORE CHRISTMAS
DAY !

BLADDER SHADOWS

by C. N. Hudson

EXCRETION urography or intravenous pyelography, as it is commonly called, has long been recognised as a leading diagnostic aid in urology. The older title of I.V.P., familiar as it is, is misleading in that it focuses attention exclusively on the pyelogram. It is true that this may be the most important part of the investigation. It is also true that the descending ureterogram may not be satisfactory as one or both ureters may never be demonstrated on any of the films. The dye which collects in the bladder, however, almost always produces a descending cystogram, which in many cases may provide useful information.

It is the practice in this hospital now to include a view of the bladder in the 20 minute or later film, if there is satisfactory concentration, in all patients over the age of 40. It is also the practice to take an AM or "after-micturating" film in the same patients. These pictures are not as a rule taken in patients under this age unless there is some special reason as, particularly in women, it involves irradiation of the gonads. For the same reason, if an I.V.P. has to be taken in pregnancy, it is usual now to take only one exposure at 20 minutes.

It is profitable to consider whether any or all of the information provided by an excretion cystogram may be provided equally well or better by cystoscopy. It is also possible that it may be better to pro-

vide this information by cystography rather than cystoscopy.

Cystography, like any opaque medium radiography, produces both positive and negative images, the latter being commonly termed "filling defects". The positive shadows are produced by dye in places where there should normally be none. Briefly, these are likely to be diverticula, fistulae, and residual urine.

Diverticula of the bladder are usually of the pulsion type, and commonly occur when

there is obstruction to the outflow of urine from the bladder. They may be diagnosed on cystoscopy, but it is very easy to miss one. Their importance lies in the fact that, if they do not drain, it will never be possible to clear an infection, such as may well follow instrumentation or prostatectomy. If a diverticulum with stasis is not removed at the time of the latter operation, trouble can ensue. Diverticula often arise in the neighbourhood of one or other ureteric orifice and as such may be hidden by

the bladder shadow in a postero-anterior cystogram. They may show up in the AM film if they do not empty, or even as an area of increased density in a cystogram. If one is suspected it is usual to take oblique views, which often demonstrate them better. A carcinoma may arise in a diverticulum and, if a cystoscope cannot pass the mouth, a cystogram may give the clue by showing a filling defect in the diverticulum. Fig. 1



Fig. 1. Trabeculation of the bladder with a large diverticulum.

shows a diverticulum of the bladder and a heavily trabeculated bladder.

Fistulae are not easily demonstrated by I.V.P. and, in any case, the diagnosis is made more easily clinically.

It is in the demonstration of residual urine that excretion cystography really comes into its own. The only other ways of doing this are by instrumentation and bimanual palpation. The latter is insensitive and difficult in fat patients. Catheterisation is studiously to be avoided in chronic retention as it invariably leads to infection (often ascending) if the bladder is allowed to fill again afterwards. The I.V.P. cystogram is therefore the safest and best way of determining the ability of the bladder to empty itself.

Filling defects of the bladder may be classified as extramural, intramural and intraluminal. Extramural filling defects arise from other objects in the pelvis, particularly gynaecological swellings. Fig. 2 shows a smooth filling defect due to an uterine fibroid. It may be said that there are easier ways of discovering fibroids, but only by this picture may the effect of the fibroid on micturition be demonstrated. This patient's urinary frequency was cured by myomectomy.

Intramural filling defects are various. Heavy trabeculation may show up in this way, but its diagnosis by this method is not important.



Fig. 2. Filling defect produced by uterine fibroid.

Most filling defects of the wall of the bladder are caused by new growths. The type of defect may be of help in establishing the stage of spread of growth. In general it may be said that if the outline of the bladder is not distorted by the defect, the growth is more likely to be benign, or still in the mucosal layer. On the other hand if the defect has an obvious indentation, as though a piece had been bitten out of the shadow, this is highly suggestive of an infiltrating carcinoma.

Fig. 3 is the appearance of papillary tumour of the bladder, and Fig. 4 is the appearance of a carcinoma infiltrating the wall.

Finally, an intravesical enlargement of the prostate may produce an intramural filling defect on cystography. Enlargement of the prostate of a size sufficient to show in this way is almost always more readily detected by other clinical means. In one particular instance, however, excretion cystography may be useful. This is in the investigation of prostatic symptoms after removal of the rectum for some other reason.

Fig. 5 shows a defect from an enlarged prostate.

In conclusion, the intraluminal defects are not important. These are either due to stone or foreign bodies, and are more readily seen on cystoscopy. Most vesical calculi, also, are radio-opaque and visible on plain film.

Fig. 3. Papillary tumour of the bladder, producing a filling defect without distortion of the bladder outline.



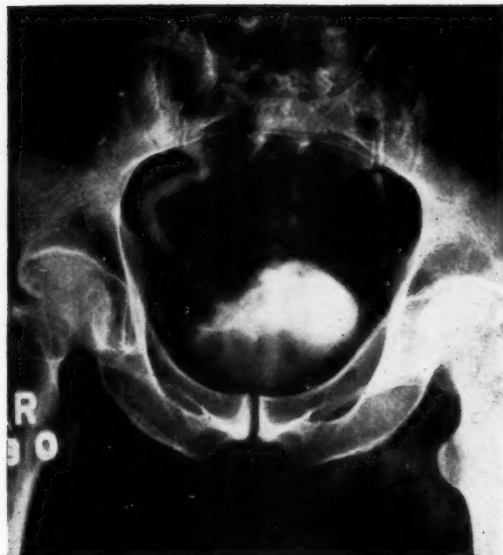


Fig. 4. Invasive carcinoma of the bladder with early ureteric obstruction.

Summary

The cystogram is an important part of excretion urography. It may provide information complementary to that obtained at cystoscopy, and may demonstrate some conditions not easily defined at the latter examination.

It is the method of choice in demonstrating residual urine in patients suspected of having a persistent inability to empty their bladders.

Acknowledgments

I thank Mr. A. W. Badenoch for advice and help in the preparation of this paper. The photographs are reproductions by the Photographic Department from the Demonstration produced for the recent Open Day at the Hospital and Medical College. The originals were provided by Mr. Badenoch and the Department of Radiology.



Fig. 5. Intra-vesical projection in benign senile hyperplasia of the prostate.

WILLIAM SMELLIE

by Elizabeth Knight

Concluding the Wix Prize Essay, 1960

His Work—The Treatise

The Treatise was published in three separate volumes and these at intervals. The first volume appeared in 1751/2 and contains the main substance of Smellie's teaching. It is the result of eleven hundred and fifty deliveries in the presence of his students as well as his considerable private practice. This volume is subdivided into chapters and sections. These are preceded by a preface and introduction in which Smellie sketches a brief history of his subject up to that time. He begins with Hippocrates and, coming nearer to his own time, he assesses Mauriceau who "published a treatise on midwifery, which exceeded everything before made public on that subject." Smellie continues, "Contemporary with Mauriceau were Dr. Chamberlen and his three sons, who practised midwifery in London with great reputation. One of these three sons, father to the late Dr. Hugh Chamberlen, translated the first volume of Mauriceau into English; and in a note upon that author's method of extracting the child by the help of the crotchet and tire-tête, affirms that his father, brothers and himself were in possession of a much better contrivance for that purpose.

"This was no other than the forceps, which they kept as a nostrum, and was not generally known till the year 1733, when a description of the instrument was published by Chapman. Long before that period indeed, several different kinds of forceps or extractors, different from those mentioned by the Arabians, were used in France, Germany and other places; but all of them fell short of the instrument used by the Chamberlens."

Smellie says that he originally had every intention of following the teachings of his predecessors—"but having by these means lost several children, and sometimes the mother, I began to alter my opinion, and consult my own reason."

Book I of this first volume gives an account of the anatomy of the pelvis with measurements, and then goes on to describe the mechanism of parturition. Sir Fielding Ould of the Dublin Lying-in Hospital was the first to doubt the current teachings that

the occiput of the foetus was towards the front of the pelvis of the mother throughout labour. Ould established that the foetal head engaged with its antero posterior diameter in the transverse axis of the pelvis. "But", says Glaister, "he complicated and obscured the problem by suggesting that in order that the head should occupy this position, the chin should be turned to one or other shoulder".

Smellie clarifies this in a revolutionary passage which expresses new ideas based entirely on his own observation, and which represents, perhaps, his greatest contribution to the science of obstetrics.

"When the head presents itself at the brim of the pelvis, the forehead is to one side, and the hindhead to the other, and sometimes it is placed diagonal in the cavity: thus the widest part of the head is turned to the widest part of the pelvis, and the narrow part of the head, from ear to ear, applied to the narrow part of the pelvis between the pubes and the sacrum. The head, being squeezed along, the vertex descends to the lower part of the ischium, where, the pelvis becoming narrower at the sides, the wide part of the head can proceed no farther in the same line of direction: but the ischium being much lower than the os pubis, the hindhead is forced in below this last bone, where there is least resistance. The forehead then turns into the hollow at the lower end of the sacrum and now again the narrow part of the head is turned to the narrow part of the pelvis. The os pubis being only two inches deep, the vertex and hindhead rise upwards from below it; the forehead presses back the coccyx, and the head, rising upwards by degrees, comes out with a half-round turn from below the share-bone: the wide part of the head being now betwixt the os pubis and the coccyx, which being pushed backwards, opens the widest space below, and allows the forehead to rise up also with a half-round turn from the under part of the os externum."

As Camper says, this was "an entirely new theory" and stresses, in Professor Johnstone's phrase "the mechanical relationships existing between the passenger and the passage".



Rymsdyk's drawing for Plate XXXV in the "Anatomical Tables", showing the use of the long curved forceps in the delivery of the after-coming head.

The rest of the book deals with a further note on anatomy and has some theories on the physiology of birth.

Book II considers the pathology of pregnancy. Smellie discusses nausea and vomiting, difficulty in making water and concludes with some theories on the causes of haemorrhage.

In Book III Smellie begins by discussing presentation. He was the first to contradict the Hippocratic theory when he avowed that the child's head is usually downwards throughout pregnancy.

There follows a note on vaginal examination. Smellie preferred the upright posture because "the weight of the uterus is more sensible to the touch than when the woman reclines."

Smellie then classifies labours thus—"I call a natural labour in which the head presents and the woman is delivered by her pains and the assistance commonly given; but should the case be so tedious and lingering that we are obliged to use extraordinary force in stretching the parts, extracting with the forceps, or (to save the mother's life) in opening the head and delivering with the crotchet, I distinguish it by the appellation of laborious; and in the preternatural I comprehend all those cases in which the child is brought by the feet, or the body delivered before the head."

In this book, too, he talks of the delivery of the placenta, showing more caution than was customary at the time—"I at first swam with the stream of general practice, till finding by repeated observation that violence ought not to be done to nature . . . I resolved to change my method, and act with less precipitation in extracting the placenta."

Smellie's "General Rules for using the Forceps", are also included in this book.

Book IV deals with the management and after care of mother and child in the immediate post natal period. It concludes with a note on the qualifications required by the perfect midwife, one of which was undoubtedly near to Smellie's heart—"She ought to avoid all reflections upon men practitioners, and when she finds herself at a loss candidly have recourse to their assistance."

Volumes II and III are the record of five hundred and thirty-one cases, the more interesting and instructive of all that Smellie attended. They are divided into forty-nine groups illustrating the points made by Smellie in Volume I. Volume II contains

mainly the laborious, and Volume III the preternatural labours of Smellie's classification. They make absorbing reading and illustrate well Smellie's integrity. Mistakes and successes alike are recorded so that his readers may learn and profit from his great experience.

The Anatomical Tables

Smellie sets out the purpose of these in his preface . . . "finding that most of the representations hitherto given of the parts subservient to uterine gestation and parturition were in many respects deficient, I have been induced to undertake the following Tables with a view to supply in some measure the defects of others, and at the same time to illustrate what I have taught and written".

He goes on to say that Dr. Camper was responsible for eleven of the Tables and that the rest were done by Mr. Rymsdyke with the exception of two by "another hand", probably Smellie's own.

Camper confirms his part in the Tables in an entry in his journal in July 1752.

"Friday 21st, I drew for Dr. Smellie and with the forceps delivered from a corpse a head in the transverse position wedged with the ear against the os pubis—Thursday 27th, I again experimented with Dr. Smellie on a corpse, delivered with forceps and made careful drawings and profiles."

The Tables illustrate in forty plates the female generative organs, the pregnant uterus at different stages, the progress of a normal labour, and many abnormal circumstances. These include the different presentations encountered and the use of forceps and the curved crotchet.

The Tables make, therefore, what Smellie intended them to be, an illustrated accompaniment to his teaching set down in the Treatise.

Smellie's Forceps

Smellie was the true pioneer in the successful use of forceps in obstetrics. It was in search of an efficient pair of forceps that he left Lanark. The pair referred to in Case 281 were "so long, and so ill-contrived, that they by no means answered the purposes for which they were intended."

London and Paris both disappointed him, and so he "began to consider the whole in a mechanical view, and reduce the extraction of the child to the rules of moving

bodies in different directions. In consequence of this plan I more accurately surveyed the dimensions and form of the pelvis, together with the figure of the child's head and manner in which it passed along in natural labours; and from the knowledge of these things. . . I have been led to alter the form and dimensions of the forceps, so as to avoid the inconveniences that attend the use of the former kind."

The main improvements which Smellie made to the design of obstetric forceps were by shortening and lightening the instrument, by inventing the "lock" and by introducing the pelvic curve. Denman describes them as "simple in their construction, applicable without difficulty, and equal to the management of every case in which forceps ought to be used".

Smellie was often criticised for using the forceps too much, but this charge cannot be supported. He himself says in his preface to Vol. II of the Treatise, "if these expedients are used prematurely, when the nature of the case does not absolutely require such assistance, the mischief that may ensue will often overbalance the service for which they were intended; and this consideration is one of my principal motives for publishing this second volume".

In the Treatise, too, are to be found his "Rules for the Safe Application of Forceps", many of which still apply in the practice of obstetrics. The forceps were used secretly at this time for, in Smellie's own words, "As women are commonly frightened at the very name of an instrument, it is advisable to conceal them as much as possible, until the character of the operator is fully established".

So his wise caution is yet again apparent.

Retirement

Smellie taught in London until the middle of 1759, when, "having made over his class, museum and teaching appliances to Dr. John Harvie, he left London and retired to his native country". So McClintock tells us.

Dr. John Harvie had married Mrs. Smellie's niece and was his heir. It is likely, then, that Smellie left London feeling that his practice and collection were in good hands and that he could enjoy the years that remained to him with an easy mind.

In fact he lived only four years more and died, according to a note on William Hunter's copy of the "Treatise", of "an

Asthma and Lethargy at his Home by Lanark in Scotland on March 5th, 1763". He was buried in the grave of his parents in the churchyard of St. Kenigern.

Epitaph

During his life Smellie evoked much controversy. He was criticised by the midwives, one of whom, Mrs. Nihell made a scurrilous attack on him. The original of Dr. Slop, in Sterne's novel "Tristram Shandy", who was Dr. Burton of York, wrote "A Letter to Dr. William Smellie, M.D., containing critical and practical Remarks upon his Treatise on the Theory and Practice of Midwifery. By



Smellie's forceps, showing the pelvic curve, in the Obstetrical Museum of the University of Edinburgh.

John Burton, M.D. Wherein the various gross Mistakes and dangerous Methods of Practice mentioned and recommended by that writer are fully demonstrated and generally corrected."

This letter ran to two hundred and thirty-three pages and was almost certainly occasioned by professional jealousy. Whatever

Smellie thought of it, he was wise enough to say nothing.

Giles Watts defended Smellie against Burton in these words.

"Dr. Smellie has made great Improvements in Midwifery, his Doctrines are judicious, and his general Method of Practice unexceptionable; and this I am well satisfied may be fully demonstrated to impartial judges notwithstanding anything that Dr. Burton has, or can, advance to the contrary: And surely he has been too unmercifully severe on a few faults."

Why did Smellie have these critics who hurled such bitter abuse at him? Glaister, in his biography of Smellie, explained it thus.

"In the first place Smellie was the chief exponent of man-midwifery and his teaching was a very large factor in the introduction of male practitioners to the practice of that art. Consequently he incurred the wrath of some, if not most of the midwives and of those who thought with them that the ordinary practice of midwifery should still remain as it had done for centuries before, solely in the hands of women.

"Secondly Smellie was probably the most prominent and best equipped teacher of his time, and in consequence invited the envy of those who felt themselves left behind in teaching, and the malice of some who believed that they were being out-stripped in practice.

"In the third place, Smellie was unquestionably the first teacher to demonstrate on correct mechanical principles, the processes of parturition and to inculcate, generally, sounder principles in obstetric practice.

"He therefore called forth the criticism of those who believed and taught the traditional doctrines chiefly by quotation from the writings of the Ancients."

But let the unknown author of a pamphlet written in 1773 on "The Present Practice of Midwifery Considered", be pressed into service to write Smellie's epitaph.

"I knew him well and he was an honest man, and not only a faithful compiler of the doctrines and sentiments of other writers on the subject, but whatever he advanced as new and properly his own was founded on real facts and observation; and what ought still more to recommend him and enforce his authority with those of his fraternity—he was an enthusiast in his profession—man-midwifery was the idol of his heart: he believed in his forceps as firmly as he did in his Bible."

Acknowledgments

I am much indebted to Messrs. E. & S. Livingstone who have most generously allowed the reproduction of the two plates. These are taken from Professor R. W. Johnstone's "William Smellie", which, together with Glaister's "Dr. William Smellie and His Contemporaries", provided much material for this essay. To them I am duly grateful.

EXPERIENCES IN BASUTOLAND

by R. C. Whalley

AFTER completing three junior house appointments I became liable for National Service and decided, for several reasons, to do a tour with Her Majesty's Overseas Service. By chance I was posted to Basutoland.

Basutoland is a mountainous country, about the size of Belgium, contained wholly within the Union of South Africa. About one quarter in the west is lowlands (5,000-6,000 ft.), the rest being highlands rising to 11,000 ft. in the Drakensberg Mountain

range. The Union's two largest rivers, the Orange and the Tugela, have their sources in this high plateau. The climate is temperate and healthy. The total population is 793,639 (1956 census) of which 1,926 are Europeans. The majority of the Africans live in the lowlands, giving a greater population density there than anywhere else in rural South Africa. The main tribe is the Basuto but, especially in the south, there are many of the Thembu tribe. These two tribes are a great contrast; the Basuto wear brightly coloured

blankets and conical grass hats, speak Sesuto and most of the men ride Basuto ponies. The Thembu, on the other hand, smear their bodies with red ochre; their clothes are simple and of the same colour. They speak a type of Xhosa and in most respects are more primitive than the Basuto.

There is a large central hospital at Maseru, the capital of Basutoland, and eight district hospitals. Each hospital supervises its own outlying clinics. The majority of the district hospitals have only one Medical Officer.

It is difficult to summarise accurately the common diseases despite annual statistics. The majority of those seen are of course coughs, colds, infectious diseases, dyspepsias and other vague aches and pains. Of the individual diseases the following are common:

car to Maseru where we spent our first year. During this year I worked with four other doctors, before being transferred to Quthing district where we are at present.

Quthing hospital has forty beds, but there are usually between ten and twenty extra patients sleeping on the floor or on mattresses. The staff is African, consisting of three Staff Nurses assisted by ward attendants. In addition the district has three mountain dispensaries, each run by a Staff Nurse. These dispensaries are only accessible on horseback or by jeep. In some districts similar dispensaries are visited by air, either in a single engined Dornier or Piper Tripacer. Magnificent views of the mountains and valleys of the interior are obtained on these flights. Some of the district hospitals have



Queen Elizabeth II hospital, Maseru.

malnutrition, presenting as pellagra, kwashiorkor and ariboflavinosis. This group is produced by a primitive culture, difficult farming conditions and by the fact that sixty per cent of the able-bodied men are working in the Union. Goitre is endemic in Basutoland due to lack of iodine in the soil. It is seen in forty-one per cent of the population. uterine fibromyomata, being easy to diagnose clinically, are commonly found, as also are vesico-vaginal fistulae.

Venereal diseases are common together with their textbook complications. Typhoid, diphtheria and tuberculosis are also frequently seen. There are no tropical diseases in Basutoland.

We arrived in South Africa at Capetown having called at Las Palmas, Ascension Island and St. Helena en route and travelled by

no X-ray units and there is no pathological laboratory in Basutoland. All specimens requiring laboratory investigation have to be sent to the Union. Therefore the majority of diagnoses is made on clinical grounds only, and so few cases of gall bladder, renal and alimentary tract diseases are diagnosed.

To give some idea of the work involved, this is the diary of a typical week:

Monday, 8.30 a.m. Urethral dilatation followed by ward rounds. On the round there would be, for example, the following cases:—fractured scaphoid with dislocation of the wrist, tuberculosis of the spine, chronic ulcer on the thigh of unknown aetiology, typhoid, compound fracture of the tibia, a P.U.O., a diabetic for stabilisation, a ruptured patellar tendon, an extra-uterine pregnancy, a tuberculous knee, a

P.I.V.D., puerperal sepsis, rheumatic fever, a caesarian section for placenta praevia, acute nephritis, lobar pneumonia, diphtheria, kwashiorkor, a fibroid uterus and a congestive cardiac failure. The other ward patients comprise pulmonary tuberculosis, maternity, infected skin lesions and lacerations, etc. After the round I go to the dispensary to see anything from thirty to one hundred and fifty patients. History is taken through interpretation. In the afternoon I see the remainder of the dispensary patients, cope with the days administrative work and do the evening ward round.

Tuesday. The same routine, but in the afternoon there are two cases from the morning's dispensary. A breast abscess for incision and drainage followed by a reduction of a supracondylar fracture of the left humerus. (This fracture is common in young boys and is often due to the boy falling off his donkey—hence locally known as “donkey fracture.”).

Wednesday. A post-mortem in the afternoon. We have much medico-legal work to do, including medical examinations in cases of rape and assault. I have also had to witness eleven executions and have had one fatal case of arsenic poisoning.

Thursday. Operation list in the morning, which in the summer starts at 6-30 a.m. (1) Hysterectomy for fibromyomata; (2) Excision of prepatellar bursa; (3) Excision of ganglion of wrist; (4) D & C; (5) Tonsillectomy; (6) Reduction of fractured radius. Theatre facilities are primitive. At the time of writing there is no theatre lamp and no sucker. All anaesthetics are “open ether,” given by the African dispenser. Instruments are sterilised by boiling over a primus burner. Operating sometimes becomes quite complicated, trying to remember what the textbook said, supervising the anaesthetic and keeping an eye on the drip!

Friday. A visit to a Mountain dispensary twenty-two miles away. The dispensary is on the other side of the Orange river which is crossed in a rowing boat. There may be between thirty and one hundred patients to be seen and I usually take back a car full who need hospitalisation. For example, a case of diphtheria and a compound fracture of the tibia on this particular visit. The majority of mountain dispensaries are situated near a Trader's store from whom the medical officer receives generous hospitality.

Saturday. There is usually a smaller dispensary in the morning and the afternoon is spent playing tennis at the Club—for my wife, while I baby-sit! Emergencies, of course, have to be dealt with, but these are few as the patient may often travel for as many as three days before reaching the hospital. Also the people fear to go out at night and so even patients within walking distance of the hospital seldom come in until the next morning. This applies to the district as opposed to Maseru where night calls were quite frequent. Our only true emergencies arise in maternity cases already in hospital.

Another week may be completely different. A visit to more distant dispensaries will mean six to eight hours of very steep and rough tracks in a Land Rover or five to six hours on horseback. We go up on Monday, to see patients all day Tuesday (sometimes as many as two hundred) and come half-way home on Wednesday. On Thursday morning we do another smaller clinic and return home in the afternoon. These “treks” provide a pleasant break from hospital routine. The scenery is fascinating and I usually find an hour or two to do some trout fishing.

Living conditions form a strong contrast with those in England. Before we left we had a 1935 Morris 8 Tourer, whereas we now have a new Ford Zephyr. We have a house servant and a garden-boy. The cost of living is low. However, shopping facilities are limited and many things have to come by post. There is little in the way of cultural entertainment. The work is interesting and rewarding, but the conditions are primitive (by modern standards) and difficult due to the very limited funds available for the medical work in this territory. The recent constitutional development in Basutoland and the fact that Her Majesty's Government is unable to accept a greater degree of responsibility for medical officers overseas who return to the United Kingdom on account of political change make it impossible to recommend this as a permanent career, but as a temporary career for the man or woman seeking experience, responsibility and the opportunity for service where it is often desperately needed, it can be strongly recommended.

* * *

LISTER AND CATGUT

by J. Ind

EVERY student of medicine is familiar with the name of Lister in connection with antiseptic surgery, but few associate the name with the modern catgut ligature which we take so much for granted.

Catgut has been known for many hundreds of years and its name is supposedly derived from the word kitgut. A kit is a fiddle, and a confusion between the words kit and cat probably resulted in the modern term catgut. The gut is prepared from the sheep's intestine by stripping off the mucous and submucous coats, scraping them free of fat and soaking them in water until they can be readily separated from one another. The submucosa is then twisted to form the finished catgut. The best fiddle strings come from Italy (Roman strings), the ill-fed, hardy sheep presumably having the toughest intestines.

In the days prior to antiseptic surgery, it was common practice to have the ends of ligatures long and hanging from the wound after tying off the larger arteries. This enabled the ligature to be pulled out after it had ulcerated through the artery. Sepsis was an almost inevitable companion to the ligature. It had long been noticed, however, that smooth metal objects and glass could remain embedded in the tissues for years with no apparent ill effects. The case of Lieutenant Gerard Fretz who lived for eight years with a large fragment from the breach of his fowling piece embedded in his ethmoid and sphenoid bones was a widely quoted illustration of this point.

Lord Lister had considered this fact and wrote, "A foreign body amongst the tissues does not exert any disturbing influence unless it be either mechanically or chemically irritating." Therefore, he reasoned, "how could silk or linen thread composed of materials of soft consistence and as unstimulating chemically as glass or steel," occasion any irritation. He was not long to realise that micro-organisms lay in the meshes of the ligatures and multiplied readily in the excellent culture medium of blood and serum in which they were bathed. He therefore

determined to experiment with sterilised ligature material and his first attempt was made on December 12th, 1867. The subject of the experiment was an old horse, the carotid artery of which was ligated with unwaxed purse silk prepared by soaking it in a saturated aqueous solution of carbolic acid for several hours. The ends were cut short, and healing was by first intention, the horse continuing in excellent health. Some six weeks later however, the horse died of exhaustion "from struggling ineffectually to rise from the recumbant posture." On dissecting the animal Lister was delighted to find the ligature unchanged but surrounded by fibrous tissue.

Lister now felt justified in using the sterilised ligature on a human subject and did so when tying the external iliac artery on a lady of 51 with a femoral aneurysm. The patient made a perfect recovery but died some ten months later after rupture of an aneurysm of the abdominal aorta. *At post mortem*, Lister found some signs of irritation caused by the silk not having been completely absorbed, and he began to cast around for a suitable material more readily absorbed.

Catgut was Lister's first substitute, and during the Christmas of 1868 he operated on a calf, tying the carotid artery in two places. One ligature was of commercial catgut and the other, home-made from ox peritoneum. A month later the calf was killed and dissected; the results delighted Lister, for both the ligatures were almost completely absorbed and their place taken by fibrous tissue.

For nearly two years after this event Lister devoted himself to experiments in order to perfect the catgut ligature. He soon realised that unprepared catgut was too readily absorbed and the knots tended to slip when the catgut was moistened by body fluids. By a strange stroke of fortune however, his problem was solved for him when he overheard a fiddler, who had come into the wards to amuse the patients, complain that his fiddle would not play well as the strings were not properly seasoned. Lister

confirmed by experiment that the catgut improved with age and further experiments led to preparation of the gut with chromic sulphate and corrosive sublimate. This was the very close forerunner of the modern chromic catgut.

Although Lister himself used catgut with absolute confidence and perfect results, some surgeons were not as successful and often obtained disastrous results. It is probably fair to say that the bad results obtained were due to either faulty technique or, more often, incorrect preparation of the gut.

Whatever the cause, however, these instances of failure using catgut, and the opposition of many eminent medical men such as Sir James Y. Simpson did much to retard the acceptance of prepared catgut as a standard form of ligature.

Nowadays catgut is used universally with the utmost confidence but it is worth bearing in mind that this modern material differs only in detail from that prepared by Lister, and also that this latter was the product of nearly five years leisure time devoted to research.

BOOK REVIEWS

ANATOMY AND PHYSIOLOGY FOR RADIOGRAPHERS—J. E. Blewett and A. M. Rackow. (Butterworths). 37/6. 322 pages, plus index and plates.

For some years there has been no text book of anatomy and physiology suitable for student radiographers. Some works, intended for medical students, are too large, detailed and costly. Others, such as books intended for nurses, have given insufficient detail concerning the special aspects of anatomy of importance to radiographers, for example, the anatomy of the skull and surface markings. Now, at long last, a book specially written for radiographers has been published and it is most welcome. Its text is comprehensive and clear. It is well illustrated with helpful line diagrams in the text and 22 plates, showing reproductions of radiographs, are included at the end of the book.

There is more than enough on nearly every subject to enable students to pass the M.S.R. examination. A more comprehensive index would have been helpful. For example, there is no mention in it of "blood" or "sinuses," although both subjects are dealt with in the text. A more detailed treatment of the para-nasal sinuses would be advantageous to students of diagnostic radiology, together with diagrams and a better illustration than plate VII (preferably the standard occipito-mental view).

Two unfortunate mistakes were noted in the text. Myeloid leukaemia (pp. 219) is said to be an overgrowth of the red cell series, whereas in fact it involves the granulocytic white cells. The function of the parathyroids (pp. 321) is described as being excretion of calcium. While it is true that urinary calcium loss may be higher than normal, the primary action of the parathyroids is to cause phosphate excretion by the kidneys (phosphate is not retained until renal failure sets in), the calcium changes being secondary.

When the next edition appears, as it is much to be hoped that it will, these and a number of very minor errors can be corrected and some parts revised to make a truly admirable all-in-one volume for the M.S.R. candidate. The authors are to be congratulated for their service to radiology in producing this book which will meet an urgent need.

D.H.T.

THE HOSPITAL GAZETEER, 1960. London, British Medical Association, viii, 163 pp. 5s.

The British Medical Association has performed an invaluable service to young doctors in compiling and publishing this booklet. It will prove useful to applicants for junior hospital appointments at any hospital in Great Britain, and records information regarding numbers of beds, special departments, staff, accommodation and amenities, noting the posts recognised for the various professional examinations.

Amenities include facilities for swimming, tennis, archery, golf, badminton, chess, etc. and the possession—or otherwise—of a library. Too many record "no library," and one hospital provides darts but no books!

This guide will require frequent revision, and new editions will obviously be called for. It is worth five shillings to any medical man.

J.L.T.

DOCTOR AGNES BENNETT. Cecil and Celia Manson. Foreword by J. C. Beaglehole. Epilogue by Agnes Bennett. London, Michael Joseph (1960). xv, 189 pp., 18s.

Biographies of living persons can be boring in the extreme, and those of doctors in particular, with few exceptions, have seldom proved successful. This must be one of the exceptions.

Dr. Agnes Bennett, O.B.E., is now eighty-eight years young, and is studying nuclear physics! Born in 1872 in Australia she took a B.Sc. at Sydney University, and having decided to study medicine, went to Edinburgh. Constantly fighting the prejudice against educated women, she practised in Wellington and at the St. Helens Hospitals.

In 1915 Dr. Bennett decided to volunteer for war service, and found herself in Salonika. The Second World War brought her back to England, still, of course, in a useful capacity. But a brief survey cannot do justice to the activities of this remarkable woman, which embrace several journeys across the world, and a career as varied as it must have been exciting.

This biography of a great lady cannot fail to inspire potential women doctors, for it was the struggles against prejudice by women such as she that have made their paths so much easier.

J.L.T.

DOCTORS AND DISEASE IN TUDOR TIMES.

By W. S. C. Copeman. *Dawson's of Pall Mall*, 1960. xiv, 186 pp. 42s.

The Fitzpatrick Lectures delivered at the Royal College of Physicians have provided some significant studies in the history of medicine, and this survey of medicine in Tudor times is no exception. The period has been much neglected, and there still remains room for a more extensive study, although this book provides most interesting reading. Chapters are devoted to "The evolution of the profession"; "Medical education"; "The Scientific basis of Tudor medicine"; "The Art of diagnosis"; "Diseases", including the plague, small-pox, syphilis, leprosy, etc.

The book is illustrated with carefully chosen plates, but one cannot help comparing the price of this work with that of a similar work on the history of surgery, published almost simultaneously at less than half the price!

Familiar names are encountered throughout the text, including Andrew Boorde, Timothy (not Thomas!) Bright, John Caius, William Clowes, Jean Fernel, and Thomas Linacre. The book contains a useful select bibliography.

J.L.T.

AN INTRODUCTION TO PHYSICAL CHEMISTRY FOR BIOLOGISTS AND MEDICAL STUDENTS, by H. R. Kruyt and J. T. G. Overbeek, translated by A. J. Mee. *Heinemann*. 25s.

This book, like the curate's egg, is good—very good—in parts. Unfortunately, the overall impression it leaves is also the same as that which the egg must have left.

The authors are distinguished experts in the field of colloid science, and have written a book which, according to the Preface, "deals with those aspects of physical chemistry which are necessary for the understanding of colloid science, and with elementary colloid science itself."

There is no doubt that colloid science is deserving of considerably more attention than it receives in the majority of text books of physical chemistry, particularly those books intended for students of biology and medicine. This book devotes approximately thirty per cent of its space to colloid science and closely related phenomena, and on the whole this section of the book would well repay study by any student of biology or medicine. With few exceptions the style is clear and lucid, and much of the subject matter is presented in an original fashion. Important aspects of colloid science, such as the behaviour of macromolecules and the effects of electrolytes and dehydrating agents on sols are dealt with in much more detail than is common in a book of this size. The only serious criticisms to be levelled at this part of the book are that once again too much emphasis is placed on lyophobic colloids, and not sufficient on lyophilic ones, since the latter are far the more important to the biologist.

If the colloid section had been expanded to fill the whole book, this might have been a very valuable book indeed. As it is, however, it would have been better if the rest of the book had never been written.

It is difficult to see what class of student might obtain some benefit from the rest of this book. Familiarity with an elementary science course is assumed, and specialised scientific terms are frequently introduced without any explanation, yet at the same time many aspects of physical chemistry are dealt with at a level which should not be necessary if any previous knowledge of science is assumed. On

the other hand, many biologists and medical students have little or no familiarity with the physical sciences before starting their courses, and these would be completely lost with such a book. Everywhere compression is carried on to such an extent that very important subjects receive dismissal in a few lines. Subjects such as pH, buffer solutions, oxidation-reduction potential, to name but a few, are very inadequately dealt with, and in far too many cases clarity has been sacrificed to brevity to such an extent that statements are made which the average student will find positively misleading, even if he can understand them at all.

Looseness of phraseology abounds. Statements such as "the concentration of the cell sap is normally greater than that of the soil solution" are quite unforgivable; in this case, which is only one of many, there is no attempt to distinguish between the vague term "concentration" and the accurate term "osmolarity"—a term, incidentally, which does not appear at all! The statement of le Chatelier's principle is also particularly bad, and there is an unfortunate tendency to use phrases such as "it is obvious that", or "it follows from the above", when it is very far from obvious, or where the connection with any preceding statement is very obscure. In one case I was completely unable to see how it followed at all; in others it certainly did not.

Many readers will also be deterred by a semi-mathematical treatment which in many cases is quite unnecessary and not in the least helpful. It certainly seems quite pointless to give what purports to be a deduction of a mathematical relationship if it is necessary in the course of the deduction to assume equations which are far more complicated than the final result, without any attempt to justify them. Since, in most cases their justification would be far beyond the capability of the reader to follow, the final results might just as well be given with no deduction at all, or simply omitted. In the deduction of the gas laws from the kinetic theory, in particular, it is unforgivable to assume that "as we know from experiment, $PV=RT$!"

It is also very annoying to find graphs and diagrams which carry no descriptive legends, and which cannot be understood without frequent searching in the text for the relevant information. In some cases also, these diagrams are quite misleading; Figure 14 shows an ordinate simply labelled "temperature", with no indication that it is freezing point which is meant; Figure 48 contradicts itself and also the table of sizes of particles on the previous page.

It is difficult to decide whether the authors, the translator, or the proof readers are responsible for the fact that the section on order of reaction on page 29 is completely nonsensical, and the accompanying table is meaningless. Certainly there are a number of cases where clumsiness of expression could be due to poor translation, and there are also a few misprints—several in mathematical expressions, which are particularly non-obvious to the casual reader, but it is difficult to understand why this book should have run to fifteen editions in Holland unless the Dutch editions are superior to the English edition in this kind of thing.

The Index is very inadequate, but this is a minor fault in comparison with all those faults which make this a book not to be recommended to anyone other than a knowledgeable physical chemist who wishes to learn a little more of colloid science.

At the same time, it must be admitted that it is refreshing to find, in such a small book—under 200

pages in all—at least a brief mention of many aspects of physical chemistry not normally met except in advanced treatises. The authors would have done far better to write an introductory book along these lines not aimed at the elementary student at all, and to have been far more careful in the matter of accuracy and clarity of expression and illustration.

G.E.F.

CLINICAL MEDICINE: The Modern Approach.
A. E. Clarke-Kennedy and C. W. Bartley. Pitman Medical Publishing Co. Ltd. 25 s.

For the clinical student, knowledge comes most easily and surely from the study of the patients he meets, and is supplemented and amplified by reading and by some of the lectures he attends. But this method of learning is haphazard, and final examinations tend to be upon him before he can attempt a synthesis of the facts and outlook he has acquired. To be able to take a broad view of medicine early in the clinical course is a much felt need, not to be met by the reading of text-books, or books on "Signs and Symptoms". This present book—*Clinical Medicine*—written with the intention of supplying this need and using a fresh approach, certainly succeeds.

To dip in more detail into its construction is, not surprisingly, to find some grounds for criticism. Here and there some of the sentences display hasty construction that makes meaning uncertain, but as a whole it is easy to read, a point of importance when considering the intention for the book. To meet, in inverted commas, many expressions used by patients to illuminate their symptoms is refreshing, but the very liberal scattering of slang and colloquial expressions in other contexts is to your reviewer, an annoyance, and their continued presence must seriously limit the value of the book in other countries. Even a yachtsman and an airman might interpret differently the sentence in which bacteria "bale out".

It could further be criticised that, for an introductory book, some concepts, e.g., osteomalacia, epilepsy, are introduced without adequate description, while one might certainly quibble with the definition of a drug of addiction.

A still broader view, a world view, of some aspects, e.g., the changing incidence of bronchial carcinoma, or of atheroma with thrombosis, could well be expected, while the section dealing with antibiotics is far from satisfactory. "Antibiotic cover" is very frequently mentioned, but its limitations hardly hinted at. There is insufficient guide concerning those diseases where bactericidal treatment is essential, or those where bacteriostasis is adequate, and the broad statement that antibiotics "must always be given in the highest possible dose devoid of risk" is untrue.

The amplifications called for might limit the space for treatment details, but this could be advantageous in that editions would less frequently go out of date.

The expressed hope that this book may be invaluable to the post-graduate student is not likely to be realised, but it will be very useful to the student starting his clinical training, and at 25s. the book is indeed very reasonably priced.

A.E.D.

BLOOD FLOW IN ARTERIES, by D. A. McDonald.
Edward Arnold (Publishers). 40s. net.

The author's aim in writing his masterly account of arterial haemodynamics is to "advance our methods of objective quantitative analysis of arterial pressure and flow". Consequently the treatment of his subject is predominantly mathematical, and that to a degree which necessarily restricts the appeal to a few specialists. This trend is becoming pretty general and undoubtedly inevitable, because of our dissatisfaction with much inaccurate observation in the past, and with the development of instruments which now, for the first time, allow more critical quantitation.

A wealth of experimental technique and know-how obviously underlies the mathematical generalisations drawn in the text; and if any criticism can be made it is merely that in a monograph of such authority the description of experimental arrangements would give the non-specialist a more practical insight. Those who have been fortunate enough to see some of the cinematographic observations on blood flow made by the author, comprehend the better the fascinating subject which he has made his own, and of which there is no more authoritative exposition than can be found in these pages.

F.E.W.

AIDS TO GYNAECOLOGY (12th Edition). W. R. Winterton, M.A., M.B., B.Ch., F.R.C.S., F.R.C.O.G.
Bailliere, Tindall and Cox. Price 10/6.

A new edition of this invaluable book, which was first published in 1885. It is an excellent, up-to-date synopsis of Gynaecology; of great use to students in conjunction with their clinical teaching, and with additional reference to larger text-books.

J.P.A.P.

BODY FLUIDS IN SURGERY, by A. M. Wilkinson, Ch.M., F.R.C.S.E., F.R.C.S., London: E. and S. Livingstone Ltd., 1960, 2nd Ed., pp. 276. 21s.

This excellent book can be strongly recommended. This revised edition incorporates new material and diagrams, and the descriptions of acid-base balance, acidosis, and alkalosis have been largely re-written. The book gives a clear account of the "content and distribution of water, sodium and potassium in the body", chapters on "sodium", "potassium", "the maintenance of chemical neutrality in the body", and an account of the metabolic effects of injury, shock, loss of gastro-intestinal secretions, and the influence of associated disease, on fluid and electrolyte balance. The diagnosis and treatment of fluid and electrolyte imbalance, with special emphasis on the problems of infancy and childhood, are ably considered. This readable, informative book gives good understanding of surgical biochemical problems, and is written by the first Nuffield Professor of Paediatric Surgery at the Institute of Child Health of the University of London.

W.M.K.

LETTER TO THE EDITOR

Sir,

An old controversy has arisen here about the origin of the sign R, which doctors affix to the beginning of a prescription. I am told that the Oxford English Dictionary maintains that it is the first letter of the Latin verb *Recipe* (take). One immediately asks why not then the plain R without the stroke through the right leg.

Sir William Osler affirms in his *Evolution of Modern Medicine* that the history of this sign goes back to Egyptian Mythology. Horus, the youthful son of Osiris and Isis, lost his one eye in a fight with Seth (either his uncle or brother), who had murdered Osiris. This eye, the symbol of sacrifice, became next to the sacred beetle the most common talisman of the country. Osler then quotes John D. Comrie in the *Edinburgh Medical Journal*, 1909, who wrote: "When Alchemy, which had its cradle in Egypt,

passed to the hands of the Greeks and later of the Arabs this sign passed with it. In a cursive form it is found in mediaeval translations of the works of Ptolemy, the astrologer, as the sign of the planet Jupiter. As such it was placed on horoscopes and upon formulae containing drugs for the administration to the body, so that the harmful properties of these drugs might be removed under the influence of the lucky planet. At present in a slightly modified form it still figures at the top of prescriptions written daily in Great Britain."

I shall be glad if a Bart's scholar can throw light on this controversial subject.

Yours sincerely,

J. van Schalkwijk.

P.O. Box 42,

Graaf-Reinet,

Union of South Africa.

SPORTS NEWS

Viewpoint

The new season has now been in swing for about a month, and most clubs which are active in the winter know how much talent they have at their disposal. The results of the Rugby Club have not been inspiring so far, though perhaps better than last year. The Soccer Club started off the season in fine form, but since then their skill has deserted them. It is to be feared that the Ladies' Hockey Club will not be the "tour de force" this year that it normally is. Many players have been lost, who have been the backbone of the side for the past few years.

One of the disadvantages of Hospital athletic activities has always been the fact that within four to five years, the membership of a club is completely changed. The standard of performance of a club can change drastically from one year to the next, while one's opponents, which are not student bodies, have approximately the same standard year after year. "team building" can never be done with an eye to the future.

Ladies' Hockey Club

The officials for the 1960-61 season are:—

<i>President:</i>	Professor A. Wormall
<i>Vice-Presidents:</i>	D. H. Lehmann Mr. D. F. Ellison Nash
<i>Captain:</i>	Miss S. Minns
<i>Vice-Captain:</i>	Miss S. Cotton
<i>Hon.-Secretary:</i>	Miss E. Knight
<i>Match Secretary:</i>	Miss A. Coates
<i>Treasurer:</i>	Miss J. Thoroughgood
<i>Committee Member:</i>	Miss E. Clements

Bart's v. King's College, at Mitcham, on Saturday, October 15th, at 2-30 p.m. Lost 2-7.

The first match of the season was played against King's College, and we were very pleased to have several new members in our team. This was a hard match to start a new season, especially with a much-changed team since last year. King's attacked strongly from the start and our defences were hard pressed, whilst our forwards had little to do. King's opened the scoring early, and had little difficulty penetrating our defence, who did not mark their opponents, and did not

recover quickly. Our forwards made little headway when given an opportunity, until our first goal was scored; then Bart's settled down better as a team and things looked more promising. The half-time score was 1-4.

In the second half Bart's had more of the play, and in spite of several corners, only managed to score once more. Our defence improved, especially the halves, but King's still made numerous attacks in the circle. Had it not been for the excellent play of our goalkeeper, the score against us would have been still higher. Goals: S. Minns (2).

Team: C. Lloyd, J. Thoroughgood, C. Foot, M. Childe, J. Evans, E. Knight, S. Lewis, N. Harker, P. Kumar, S. Minns, J. Swallow.

October 19th, —Match v. Queen Mary College, at Chislehurst, Result: Lost 13-0.

This was annihilation! Q.M.C. had a very good team, well-knit together and they opened the scoring from the first whistle and scored four goals in the first ten minutes, whilst Bart's could only field 10 players. After this Bart's fought back and held them off for a while but more goals came inevitably, and at half-time the score was 7-0. In the second half Bart's were somewhat improved. The half-backs fought desperately in defence, led by the tireless Miss Knight, and the forwards moved better together and had a few near misses. However the forwards must find much more thrust and the backs more determination in the tackle if we are to beat teams such as Q.M.C.

Team: S. Cotterell; G. Turner, C. Foot; J. Thoroughgood, E. Knight, T. Coates; R. Walters, N. Harker, E. Clements, P. Kumar, S. Cotton.

Rifle Club

At the Annual General Meeting of the Rifle Club, held on October 13th, the following officers were elected for the year 1960-1961:—

<i>President:</i>	Mr. H. Jackson Burrows
<i>Vice-Presidents:</i>	Dr. G. E. Francis Dr. Aumonier Mr. G. L. Bourne Mr. R. Farrow

<i>Captain:</i>	A. M. Ward
<i>Hon. Sec., Fullbore:</i>	A. M. Pollock
<i>Hon. Sec., Smallbore:</i>	F. J. R. Hardy
<i>Hon. Treasurer:</i>	Miss Z. N. C. Gardner
<i>Committee Members:</i>	P. N. Riddle R. S. Thompson

Soccer

1st XI v. St. Mary's Hospital on October 1st (H).

Bart's 2, St. Mary's 1.

This match proved a very encouraging start to the season. Bart's, inspired by the fine leadership of J. Jailler, were just a little too strong for St. Mary's.

The Hospital fought back from a 1-0 deficit, and equalised through D. Prosser. The winning goal was scored by L. Iregbulem after a fine midfield passing movement. This latter goal illustrated well the possibilities of the Hospital XI this season, and further, it showed that even in inter-hospital football brain can triumph over brawn.

Team:—J. Spivey; G. Haig, A. Howes; J. Jailler, (Capt.), B. Hore, G. Gardos; P. Stanley, H. Phillips, L. Iregbulem, D. Prosser, B. Dodd.

1st XI v. Swiss Mercantile College on October 8th (H)

Bart's 2, Swiss Mercantile College 2.

Bart's might well have won this game had a little more skill been substituted for abundant enthusiasm.

The strength of Bart's lay at half-back where Jailler, Hore and freshman Hudson played consistently. The Swiss team gained an early lead, but scores were levelled when a Swiss defender placed an admirable lob over his own goalkeeper's head.

Iregbulem scored a magnificent goal from 20 yards to give Bart's the lead, which however, was soon to be lost.

This result was very encouraging for all concerned.

1st. XI v. City of London College, on October 15th (A)

City of London College 4, Bart's 2.

Bart's should not have lost this game. The opposition consisted of players that were at their best perhaps 10 or 20 years ago. The Hospital took the lead through Herbert, but were fairly soon to be 3-1 down.

Phillips reduced the lead but the "old campaigners" retained their lead till the end.

Rugby Football

1st XV v. Reading on September 26th (A).

Result: Reading 3 pts., Bart's 5 pts.

Conditions were ideal for the first game of the season and Bart's kicked off, uphill into the sun on a springy pitch.

The first half produced some good probing three-quarter movements on both sides and M. Britz drew some appreciative applause with his tackling. Reading achieved a slight superiority in the lines-out and half-time came with them leading by a penalty goal to nil.

Early in the second half there were some tense moments and Bart's twice lost their chance to equalise when P. A. R. Niven failed to kick penalty goals from relatively easy positions. However, following a loose scrum M. C. Jennings picked up and went over near the posts. Niven converted.

J. E. Stevens' vigorous pre-season training sessions now paid off and with tails up and superior fitness telling, the Bart's team spent the last fifteen minutes attacking strongly, but no further score resulted.

Team: P. A. R. Niven, J. E. Stevens, M. Britz, P. M. Perry, R. V. Jeffreys, R. R. Davies, I. M. Peek, A. J. S. Knox, M. C. Jennings, J. A. Harvey, M. M. Orr, B. R. H. Doran, R. P. Davies, P. D. Moynagh, D. Goodall.

1st XV v. Trojans on October 1st at Chislehurst.

Result: Bart's nil, Trojans 6 pts.

This was a very disappointing performance indeed for, despite an almost embarrassing amount of the ball from both scrums and lines-out, and a clear territorial advantage in both halves, Bart's contrived to lose this game by a try and a penalty goal to nil. Weakness in the centre and some unintelligent play among the backs as a whole largely contributed to the outcome and at the end the Hospital had only a series of near misses to set against 6 pts.

Trojans took their opportunities with a penalty goal in the first half and a try in the second, following a scrum on the Bart's line during a rare excursion into the home twenty-five. They defended well throughout and displayed much enthusiasm, particularly in the loose. Summarising then, this was not an impressive display and one which the 1st XV might do well to forget rather quickly.

Team: Niven, Stevens, J. K. Bamford, Jeffreys, G. J. Halls, Davies (R. R.), Peek, Knox, B. H. Gurry, J. W. Hamilton, Orr, Doran, Davies (R. P.), Jennings, Goodall.

1st XV v. Woodford on October 8th (A).

Result: Woodford 5 pts., Bart's nil.

On a very wet and dull day the Hospital went down by a goal to nil. The pack, well lead by M. C. Jennings, fought hard against their heavier opponents and were only dominated for a brief period just after the interval during which time Woodford scored, following a blind-side break by their scrum-half. Hooker B. H. Gurry, striking very fast gained several scrums against the loose head but with the half-backs playing together for the first-time and the slippery ball, the outsiders were not able to take advantage of this.

Bart's came close to scoring in the second half when first M. M. Orr and then D. Goodall were hauled down just short of the line and a short penalty for the Hospital, taken from under their opponent's posts only just failed to bear fruit in the closing stages.

A game played in bad conditions that served to emphasise the defensive ability but lack of attacking power of the Bart's team.

Team: Niven, Stevens, Bamford, A. T. Letchworth, Jeffreys, Britz, Peek, Knox, Gurry, Hamilton, Orr, Doran, Jennings, C. J. Smart, Goodall.

1st XV v. Cambridge University LX Club on October 12th (at Chislehurst).

Result: Bart's 3 pts., C.U. LX Club 9 pts.

In a fast, open, and often exciting game at Chislehurst, Cambridge LX Club beat Bart's by two tries and a penalty goal to one penalty goal, a margin that was only prevented from being greater by the LX Club's poor finishing and the predatory tackling and covering of the Bart's team as a whole. The heavier LX forwards completely dominated the lines-out, gained a majority in the tight and were responsible for their side's opening score—an unconverted pushover try. This was followed quickly by a well-taken penalty goal and just after half-time, LX Club's opportunist right wing dashed twenty yards to the corner to complete a good handling movement. In reply J. E. Stevens kicked a penalty goal from 35 yards close on time. For Bart's, Stevens and Jeffreys ran well, and although the Hospital matched the undergraduates for fitness, they could not match the ingenuity and creative efforts of their opponents.

Team: Niven, Stevens, Letchworth, Bamford, Jeffreys, Britz, Peek, Knox, Gurry, Hamilton, Doran, Orr, Jennings, Smart, Goodall.

1st XV v. United Industries on October 15th (A)

Result: United Industries 12pts., Bart's 19 pts.

United Industries, a new venture, comprising representatives from several London major industrial concerns, made their debut at Southgate on Saturday in losing to Bart's Hospital by three penalty goals and a try to two goals, two tries and a penalty goal. Conspicuous for their enthusiasm rather than their ability the Industries opened the scoring with a penalty goal through their admirable full-back T. Frith. However, aided by a majority of the ball from the set pieces and loose tackling by their opponents, the Hospital backs were able to put in several strong runs and steadily establish a clear lead. In this respect, mention should be made of M. Britz, who scored one try and made another for M. M. Orr. The Bart's pack pushed over for a further score and then A. T. Letchworth and R. R. Davies contrived a clean break for the latter to ground under the posts. J. E. Stevens converted two tries and kicked a penalty goal. Meanwhile Frith had increased the Industries' tally with two more penalty goals and just on time, M. Hulley, on the right wing, crossed after a quick heel from the loose on the left to complete the scoring.

Team: Niven, Stevens, Britz, Letchworth, Jeffreys, Davies, Peek, Knox, Gurry, Hamilton, Doran, Orr, Jennings, Smart, Goodall.

1st XV v. Old Blues on October 22nd (A)

Result: Old Blues 25 pts., Bart's nil.

In murk and drizzle and on a pitch abounding with puddles, Bart's took on the unbeaten Old Blues at Fairtop and went down by five goals to nil. From the outset it was a forward battle with the ball rarely going beyond the stand-off halves both of whom kicked to advantage.

For the Hospital, Gurry hooked well, Orr jumped high and effectively in the lines-out and Peek toiled bravely at the base of the scrum. Half-time came with Old Blues one goal up scored after a neat movement by their back row, but Bart's were still very much in the game. However, after the interval the home side ever dangerous with the ball at their feet, helped themselves to a further twenty points. Among the factors contributing to this final rout were astute tactics from the Blues' stand-off, the pulled hamstring of his opposite number, a place-kicker who achieved all but perfect accuracy, and indecisive tackling and poor covering by the Bart's team as a whole.

Summarising, this was a disappointing Bart's performance with the team showing little adaptation to the conditions, and one in which the defence, hitherto outstanding, displayed gross inadequacies.

Team: Niven, Stevens, Bamford, Letchworth, Jeffreys, Britz, Peek, R. J. Shearer, Gurry, Hamilton, Doran, Orr, Jennings, Smart, Goodall.

Bridge Club

The Bridge Club has retained the Hospital's Cup for the third year running, this time, however, it was far from being easy.

In the first round the Bart's second team: A. Stewart—R. England, P. Evison—R. Harrison went down to King's I and Bart's III: J. Scobie—J. Bamford, D. Abell—A. Geach lost to St. Thomas's C. The first team had a bye and met King's I, last year's defeated finalists in the semi-final. The Bart's team: D. Gray—A. Garrod, R. England—G. Gardos, finished 2 match points up after 28 boards being 11 down at the half-way stage. Since the four extra boards did not produce the required winning margin of 5 match-points the match was drawn and had to be replayed. This resulted in an easy win for us (+27 match points), putting us into the final, where we met St. Mary's.

The Bart's team: D. Gray—A. Garrod, F. Abercrombie—G. Gardos, started well and were 9 match points up after 14 boards. In the second half of the match, however, disaster struck and owing to some bad mistakes our team finished the 28 boards one match point down. The first three of the four extra boards did not alter the position when good fortune, or perhaps divine justice, came to our aid and at game all the following hands were dealt:

S. Q x x				S. x x
H. J 10 x x x x	W	E	H. K x x	
D. x x			D. 10 x x x x	
C. x x			C. Q J 10	
			N	S. K J 10 x x x
			S	H. Q x x
				D. K Q
				C. K x
				S. A x
				H. A
				D. A J x x
				C. A x x x x x

At the table where Abercrombie and Gardos were sitting North and South, the bidding went:

S	W	N	E
—	No	No	1S
3C	No	3D	No
5D	No	No	No

Abercrombie's 3D bid is imaginative, if his suit is not supported by South there are still good prospects for game in Clubs. East led a heart taken by the Ace in dummy, followed by Ace and another trump. The trumps splitting 2-2 and the King of Clubs successfully finessed later North made his contract with an over-trick. Against an opening spade lead North cannot make the over-trick because it is impossible to get rid of the spade loser in time.

At the other table the diamond suit was not bid and the Mary's N—S pair went to 5 Clubs, Gray sitting East having opened the bidding with 1S. Garrod, sitting West led a low Spade taken by the Ace in the closed hand. The situation is now entirely different from the other table. Playing in Clubs instead of Diamonds South could not see any way of entering into dummy to take the Club finesse. He played the Ace of trumps trying to drop a singleton King, but as the King was guarded he lost a trump, a Spade and a Diamond and was one down. Garrod's Spade lead is excellent, for the safe trump lead or a Diamond lead would be disastrous here. But even against a Spade lead there is an ingenious way of making the contract. South takes the Spade lead with the Ace, cashes the Ace of Hearts, the Ace of Diamonds and plays a low Diamond to East's King. East thrown in, because after cashing in his good Spade K he cannot prevent North from getting in with the HK or a ruff and take the Club finesse, losing only two tricks. This is not a "double dummy" problem, for the chances of the 2-2 split in Diamonds and

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finding the CK on the right side are greater than finding the Club King singleton. Besides, E's opening bid invites the finesse against him.

The swing on this last hand gave us the winning margin of 5 match points and the signal to open a bottle of champagne and celebrate our close but well-deserved victory.

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